

RANCHO LOS AMIGOS NATIONAL REHABILITATION CENTER
Center for Applied Rehabilitation Technology (CART)

Name: _____

Date: _____ **Sex:** F / M

RLANRC#: _____

Primary Language: _____

Permanent Address

Address: _____

Home Phone #: (____) _____

City: _____

Work# (____) _____

State: _____ **Zip Code:** _____

Fax #: (____) _____

County: _____

Email: _____

Temporary Address (if applicable)

Address: _____

Home Phone #: (____) _____

County: _____

City: _____

State: _____ **Zip Code:** _____

SSN#: _____ **Date of Birth:** _____

Age: _____ **Marital Status:** _____

Birth Place: _____ **Race:** _____
(State or Foreign Country)

Spouse Name: _____

Parent/Guardian: _____

Patient is a minor: Mom's SSN #: _____

OR Dad's SSN#: _____

Date of Birth: _____

Date of Birth: _____

Mother's Maiden Name: _____

Father's Full Name: _____

Emergency person: _____

Relationship: _____

Address: _____

Home Phone #: (____) _____

Cell Phone/Pager #: (____) _____

City: _____ **State:** _____ **Zip Code:** _____

Medical Diagnosis: _____ **Date of Onset:** _____

Use Ventilator: Yes / No

Tracheostomy: Yes / No

Able to speak: Yes / No

Primary Physician Name: _____ **License #:** _____ **UPIN#:** _____

(Only for Medicare patients)

Address: _____ **Phone #:** () _____

City: _____ **State:** _____ **Zip Code:** _____

Consultation Request/Rancho Physician name: _____

Clinic Name: _____

Ext. No: _____

Living Situation: (check one) ☐ Lives independently ☐ Nursing Home (**SNF**) ☐ Hospital
☐ Group facility ☐ Family home ☐ Sub Acute

Daytime Activities: (check one) ☐ Work ☐ Attends School: ☐ Full-time ☐ Part-time
☐ Other (specify) _____

Referral Information: Reason for referral (check all that apply)

☐ Seating ☐ Mobility ☐ Augmentative Communication ☐ Computer Access
☐ Worksite Evaluation ☐ EADL (electronic aids for daily living) ☐ Other _____

Goals/Expectations: _____

Funding sources:

Medicare#: _____ **CCS Case #:** _____

Part A - eff. date: _____ **CCS Authorization #:** _____

Part B - eff. date: _____ **Other (specify)** _____

Medi-cal #: _____

Medi-cal Issue Date: _____

Referral source:

Name: _____ Agency: _____

Address: _____ Phone #: (____) _____

_____ Cell Phone/Pager #: (____) _____

City: _____ Fax#: (____) _____

State: _____ Zip Code: _____ E-Mail: _____

Comments: _____

(CART Use only)

Appt. Date: _____ Time: _____ Rescheduled Appt. Date: _____ Time: _____

Scheduled with: _____ Scheduled with: _____